

**Attachment E.B.  
to Appendix E**

**Family Care Individual  
Service Plan**



**ISP FOR FAMILY CARE PARTICIPANTS**

Waiver Type: FE/PD ____ DD ____	Case Manager: _____ SW _____ RN		
Member Name	Functional Screen Date	LOC Determination Date	Initial Comprehensive Assessment Date
Address: Street, City, State, Zip	CMO Enrollment Date	CMO Disenrollment Date	Last Reassessment Date
	Level of Care  Comp. ____  Int. ____	Target Group FE ____  DD ____  PD ____	Initial Service Plan Development Date:  Last Update:
Telephone Number	LOC Reevaluation Due Date(Re-certification)	Self Directed Support Option: Yes ____ No ____ If yes, name of broker: _____	
Medicaid Number:	Planned Community Living Arrangement Type		Cost Share Amount \$
Name of Guardian	Guardian Telephone: Home _____ Work _____		
Guardian Street Address _____ City, State, Zip _____			
In Case of Emergency Notify Name	Telephone: Home _____ Work _____		
Street Address	City, State, Zip	Relationship	

\* The member's detailed ISP must address all 15 domains, that is, strengths or needs should be identified for each domain. For each outcome/consumer preference indicate which domain it is addressing. A single consumer outcome/preference may address multiple domains simultaneously.

[illegible]



<b><u>FAMILY CARE INDIVIDUALIZED SERVICE PLAN</u></b> Service Detail for: _____ (Member Name)		
DOMAIN*	CONSUMER OUTCOMES: Detailed Preferences:	INTERVENTION / SERVICES
1. ADLs & IADLs		
2. Physical health & Medical needs		
3. Nutrition		
4. Autonomy & Self determination		
5. Communication & Social Participation		
6. Mental Health & Behavioral		
7. Cognitive:		
8. Informal Supports		
9. Rights & Responsibilities.		
10. Community		



<b><u>FAMILY CARE INDIVIDUALIZED SERVICE PLAN</u></b> Service Detail for: _____ (Member Name)		
DOMAIN*	CONSUMER OUTCOMES: Detailed Preferences:	INTERVENTION / SERVICES
Integration  11. Safety  12. Personal Values  13. Education  14. Economic resources  15. Religious Affiliation		



**ISP FOR FAMILY CARE PARTICIPANTS**  
**Signature Page for Initial Individualized Service Plan**

Member Name	Member Telephone
Case Manager	Case Manager Telephone

**Policy:** The CMO must offer the member the freedom to choose between and among needed services and providers that are in the CMO's network. Members must also be afforded the opportunity to participate in the development of the ISP. The signatures below indicate that the member, to the extent he or she desires, or the member's representative has participated in the ISP process from the date of enrollment and throughout the time the member was enrolled in the CMO.

**Member Signatures for Initial ISP**

**Individualized Service Plan (started within 5 days of enrollment in the CMO)**

My service plan was started on this date: \_\_\_\_\_

My signature: \_\_\_\_\_

**✓ yes or no box**  
**YES NO**

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**Individualized Service Plan (completed within 60 days of enrollment in the CMO)**

I have been offered the choice to develop my own plan

I have been offered the choice of directing my own services

I agree with all of my plan as developed by me and the CMO team

I disagree with part of my plan as developed by me and the CMO team

**YES NO**


The reason I disagree with part of my plan is:

I have received a copy of my plan on \_\_\_\_\_  
(date)

I have received a copy of my rights to file a grievance, have a state review, or have a fair hearing.

**YES NO**


**Date**

My signature \_\_\_\_\_

Signature of my authorized representative \_\_\_\_\_

Signature of CMO Team Member \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



### CMO Signatures

**If the member and the CMO do not agree on the service plan and the member wishes to file a grievance or request a DHFS review or a fair hearing, the CMO shall offer its service plan for the enrollee and document that the service plan meets all of the following conditions:**

I certify that this ISP reasonably and effectively addresses all of the long-term care needs and outcomes identified in the member's comprehensive assessment, and is cost-effective compared to alternative services or supports that could meet the same needs and achieve similar outcomes.

I certify that the ISP will not have a significant, long-term negative impact on the member's long-term care outcomes.

I certify that the ISP balances the needs and outcomes identified by the assessment with reasonable cost, immediate availability of services and the ability of the CMO to develop alternative service and living arrangements.

I certify that the ISP was developed after active negotiation between the CMO and the member, during which the CMO offered to find or develop alternatives - which would be more acceptable to both parties.

Signature of CMO Case Manager

Date Signed

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**ISP FOR FAMILY CARE PARTICIPANTS**  
**Signature Page for Up-Dated and/or Revised Individualized Service Plan**

Member Name	Member Telephone
Case Manager	Case Manager Telephone

**Policy:** The CMO must offer the member the freedom to choose between and among needed services and providers that are in the CMO's network. Members must also be afforded the opportunity to participate in the development of the ISP. The signatures below indicate that the member, to the extent he or she desires, or the member's representative has participated in the ISP process from the date of enrollment and throughout the time the member was enrolled in the CMO.

**Member Signatures for Up-dated/Revised ISP**  
**Individualized Service Plan (started within 5 days of enrollment in the CMO)**

My service plan was started on this date: \_\_\_\_\_

My signature: \_\_\_\_\_

✓ yes or no box  
**YES                  NO**

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**Individualized Service Plan (completed within 60 days of enrollment in the CMO)**

I have been offered the choice to develop my own plan

I have been offered the choice of directing my own services

I agree with all of my plan as developed by me and the CMO team

I disagree with part of my plan as developed by me and the CMO team

**YES                  NO**


The reason I disagree with part of my plan is:

I have received a copy of my plan on \_\_\_\_\_  
(date)

I have received a copy of my rights to file a grievance, have a state review, or have a fair hearing.

My signature \_\_\_\_\_

Signature of my authorized representative \_\_\_\_\_

Signature of CMO Team Member \_\_\_\_\_

**YES                  NO**


**Date**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



### CMO Signatures

**If the member and the CMO do not agree on the service plan and the member wishes to file a grievance or request a DHFS review or a fair hearing, the CMO shall offer its service plan for the enrollee and document that the service plan meets all of the following conditions:**

I certify that this ISP reasonably and effectively addresses all of the long-term care needs and outcomes identified in the member's comprehensive assessment, and is cost-effective compared to alternative services or supports that could meet the same needs and achieve similar outcomes.

I certify that the ISP will not have a significant, long-term negative impact on the member's long-term care outcomes.

I certify that the ISP balances the needs and outcomes identified by the assessment with reasonable cost, immediate availability of services and the ability of the CMO to develop alternative service and living arrangements.

I certify that the ISP was developed after active negotiation between the CMO and the member, during which the CMO offered to find or develop alternatives - which would be more acceptable to both parties.

Signature of CMO Case Manager

Date Signed

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